

PRINTED: 06/19/2014  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN9502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - STATE BUILDING  B. WING: _____	(X3) DATE SURVEY COMPLETED  06/16/2014
NAME OF PROVIDER OR SUPPLIER  LEBANON HEALTH AND REHABILITATION CEI		STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  Based on observations, testing, and records review on 6/16/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

80VP21

7-2-14  
If continuation sheet 1 of 1